

Perspective: Essential Study Quality Descriptors for Data from Nutritional Epidemiologic Research

Chen Yang,¹ Mariona Pinart,⁵ Patrick Kolsteren,¹ John Van Camp,¹ Nathalie De Cock,¹ Katharina Nimptsch,⁵ Tobias Pischon,⁵⁻⁸ Eamon Laird,⁹ Giuditta Perozzi,¹⁰ Raffaella Canali,¹⁰ Axelle Hoge,¹¹ Marta Stelmach-Mardas,^{12,13} Lars Ove Dragsted,¹⁴ Stéphanie Maria Palombi,¹⁴ Irina Dobre,¹⁴ Jildau Bouwman,¹⁵ Peter Clarys,¹⁶ Fabio Minervini,¹⁷ Maria De Angelis,¹⁷ Marco Gobetti,¹⁸ Jean Tafforeau,¹⁹ Oscar Coltell,^{20,21} Dolores Corella,^{21,22} Hendrik De Ruyck,²³ Janette Walton,²⁴ Laura Kehoe,²⁴ Christophe Matthys,²⁵ Bernard De Baets,² Guy De Tré,³ Antoon Bronselaer,³ Angela Rivellesse,²⁶ Rosalba Giacco,²⁷ Rosario Lombardo,²⁸ Sofian De Clercq,²⁹ Niels Hulstaert,^{4,30} and Carl Lachat¹

Departments of ¹Food Safety and Food Quality, ²Mathematical Modelling, Statistics and Bioinformatic, ³Telecommunications and Information Processing, and ⁴Biochemistry, Ghent University, Ghent, Belgium; ⁵Molecular Epidemiology Research Group, Max Delbrück Centre for Molecular Medicine, Berlin, Germany; ⁶Charité – Berlin University of Medicine, Berlin, Germany; ⁷Max Delbrück Center for Molecular Medicine and Berlin Institute of Health, Berlin, Germany; ⁸German Centre for Cardiovascular Research, partner site, Berlin, Germany; ⁹Vitamin Research Group, Trinity College Dublin, Dublin, Ireland; ¹⁰Food and Nutrition Research Centre, Rome, Italy; ¹¹Department of Public Health, University of Liège, Liège, Belgium; ¹²Department of Epidemiology, German Institute of Human Nutrition Potsdam-Rehbruecke, Nuthetal, Germany; ¹³Department of Pediatric Gastroenterology and Metabolic Diseases, Poznan University of Medical Sciences, Poznan, Poland; ¹⁴Department of Nutrition, Exercise and Sports, University of Copenhagen, Frederiksberg, Denmark; ¹⁵Netherlands Organisation for Applied Scientific Research, Zeist, Netherlands; ¹⁶Vrije Universiteit Brussels, Brussels, Belgium; ¹⁷Department of Soil, Plant and Food Science, University of Bari Aldo Moro, Bari, Italy; ¹⁸Faculty of Science and Technology, Free University of Bozen-Bolzano, Bolzano, Italy; ¹⁹Department of Public Health and Surveillance, Scientific Institute of Public Health, Brussels, Belgium; ²⁰Department of Computer Languages and Systems, University Jaume I, Castellón, Spain; ²¹Department of Preventive Medicine and Public Health, University of Valencia, Valencia, Spain; ²²Biomedical Research Centre in Physiopathology of Obesity and Nutrition, Institute of Health Carlos III, Madrid, Spain; ²³Flanders research institute for agriculture, fisheries and food, Technology and Food Science Unit, Food Safety and Product Innovation, Melle, Belgium; ²⁴School of Food and Nutritional Sciences, University College Cork, Cork, Ireland; ²⁵KU Leuven, Clinical and Experimental Endocrinology and University Hospitals Leuven/KU Leuven, Department of Endocrinology, Campus Gasthuisberg, Leuven, Belgium; ²⁶Department of Clinical Medicine and Surgery, School of Medicine, University Federico II, Naples, Italy; ²⁷Institute of Food Sciences of National Research Council, Avellino, Italy; ²⁸The Microsoft Research, University of Trento Centre for Computational and Systems Biology, Trento, Italy; ²⁹Department of Biochemistry, Ghent University, Faculty of Medicine and Health Sciences, Ghent, Belgium; and ³⁰VIB-UGent Center for Medical Biotechnology, VIB, Ghent, Belgium

ABSTRACT

Pooled analysis of secondary data increases the power of research and enables scientific discovery in nutritional epidemiology. Information on study characteristics that determine data quality is needed to enable correct reuse and interpretation of data. This study aims to define essential quality characteristics for data from observational studies in nutrition. First, a literature review was performed to get an insight on existing instruments that assess the quality of cohort, case-control, and cross-sectional studies and dietary measurement. Second, 2 face-to-face workshops were organized to determine the study characteristics that affect data quality. Third, consensus on the data descriptors and controlled vocabulary was obtained. From 4884 papers retrieved, 26 relevant instruments, containing 164 characteristics for study design and 93 characteristics for measurements, were selected. The workshop and consensus process resulted in 10 descriptors allocated to “study design” and 22 to “measurement” domains. Data descriptors were organized as an ordinal scale of items to facilitate the identification, storage, and querying of nutrition data. Further integration of an Ontology for Nutrition Studies will facilitate interoperability of data repositories. *Adv Nutr* 2017;8:639–51.

Keywords: data quality, observational study, dietary assessment, nutritional epidemiology, data interoperability

Introduction

Poor diets are among the leading causes of disease and inadequate health worldwide (1). Observational studies are an essential source of information in nutritional epidemiology. They assess the relation between diet and health outcomes (2, 3)

and allow for the inference of findings from mechanistic and laboratory studies in free-living populations (4). Observational studies need to be adequately powered for this purpose, which requires substantial funding, resources, participant involvement, and time. Reuse of secondary data can increase

the return on investments from observational studies. Apart from providing additional power, the analysis of secondary data can allow for the assessment of the robustness of findings across study settings, study design, and participants (5). The Global Burden of Disease (1), the Non-Communicable Disease Risk Factor Collaboration (6), and the Global Dietary Database (7) demonstrate how the reanalysis of secondary data can generate new insights into diet, nutrition, and human health.

Sharing research data has gained considerable momentum. Despite this, however, low accessibility (i.e., difficulties in finding appropriate secondary datasets) and validation of data (i.e., challenges in identifying the characteristics of available data sets as well as their collection method) remain key concerns for secondary data analysis in epidemiology (8). A key requirement to enable effective use and machine readability of research data is the use of appropriate data descriptors (9). To date, however, no consensus has been reached on the required metadata for nutritional studies.

Knowledge of data quality is key to interpreting findings of secondary analyses. It enables the performance of uncertainty analysis of risk factors for disease (10) and is of interest for comparing data sets and their contribution to overall findings in pooled analysis (11, 12). Quality tools exist for epidemiologic research (13) but are designed to appraise the quality of the study findings, rather than the study data, and are influenced by the reporting quality of the study or judgement of external assessors. Research data, however, can be (re)used for different research questions. Because secondary data analysis may demand specific data quality, a clear description of data characteristics by data providers is needed.

The present report provides guidelines to facilitate the collection of a uniform set of information (i.e., data descriptors) from nutritional epidemiologic studies. This information would be helpful to describe the quality of available data from observational nutrition studies in the event researchers attempt to pool data and perform secondary analyses.

Perspective articles allow authors to take a position on a topic of current major importance or controversy in the field of nutrition. As such, these articles could include statements based on author opinions or point of view. Opinions expressed in Perspective articles are those of the author and are not attributable to the funder(s) or the sponsor(s) or the publisher, Editor, or Editorial Board of *Advances in Nutrition*. Individuals with different positions of the topic of a Perspective are invited to submit their comments in the form of a Perspectives article or in a Letter to the Editor.

ENPADASI (European Nutritional Phenotype Assessment and Data Sharing Initiative) is part of the Joint Programming Initiative “a healthy diet for a healthy life” and is funded by national funding agencies in 9 European countries. The work in this manuscript is funded by the FWO Research Foundation–Flanders, grant number GOD4815N and the German Ministry of Food and Agriculture through the Federal Office for Agriculture and Food, grant number 2814ERA01F. CY is funded by a scholarship from the Chinese Scholarship Council. CL received funding from Bioversity International for the work on standards for dietary assessment. LOD received funding from The Innovation Fond Denmark (grant number 4203-00001B). This is a free access article, distributed under terms (<http://www.nutrition.org/publications/guidelines-and-policies/license/>) that permit unrestricted noncommercial use, distribution, and reproduction in any medium, provided the original work is properly cited.

Author disclosures: CY, MP, PK, JVC, NDC, KN, TP, EL, GP, RC, AH, MS-M, LOD, SMP, ID, JB, PC, FM, MDA, MG, JT, OC, DC, HDR, JW, LK, CM, BDB, GDT, AB, AR, RG, RL, SDC, NH, and CL, no conflicts of interest.

Supplemental Table 1 is available from the “Online Supporting Material” link in the online posting of the article and from the same link in the online table of contents at <http://advances.nutrition.org>.

Address correspondence to CL (e-mail: carl.lachat@ugent.be).

Abbreviations used: DASH-IN, Data Sharing In Nutrition; ENPADASI, European Nutritional Phenotype Assessment and Data Sharing Initiative; ONS, Ontology for Nutritional Studies.

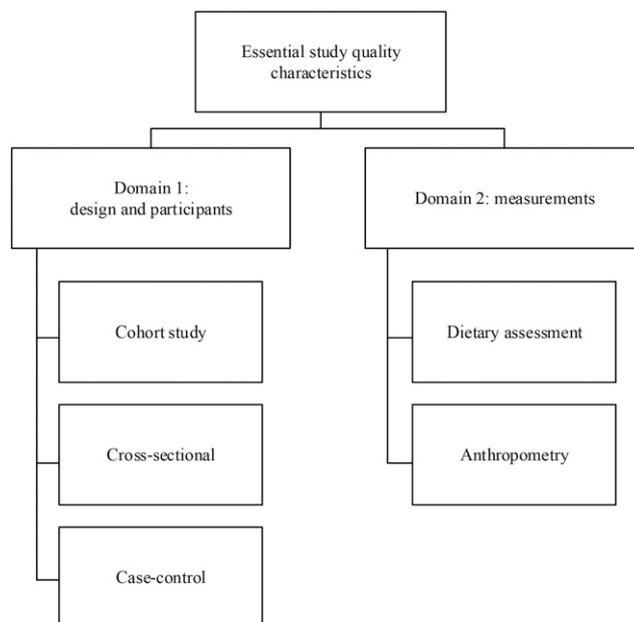


FIGURE 1 The domain-based structure of the essential study quality characteristics.

This study was performed in the context of ENPADASI (European Nutritional Phenotype Assessment and Data Sharing Initiative), a collaborative effort of 16 multidisciplinary consortia from 50 research centers in 9 countries. ENPADASI aims to enable sharing and reuse of existing nutritional data through a nutritional data infrastructure called DASH-IN (Data Sharing In Nutrition) (14).

Methods

This study was organized in 3 consecutive steps. First, a systematic literature review was performed to identify existing tools that assess quality of observational studies. Second, face-to-face and online meetings with the relevant ENPADASI partners were organized to determine the descriptors and their structure. Third, we built consensus on the descriptors. A controlled vocabulary was developed to avoid ambiguity and facilitate understanding of descriptors and wording.

Step 1: literature review

To guide the literature review, a scoping study was conducted to identify available study quality appraisal tools and reviews on the topic. The websites of the Scottish Intercollegiate Guidelines Network initiative (15) and Cochrane Handbook (16) were searched, and a citation analysis of systematic reviews on the topic (13, 17–19) and reporting guidelines (20) were performed. The scoping study confirmed the lack of existing tools for describing the quality characteristics of study data from nutritional epidemiology. Existing instruments and standards in biosciences, such as the “investigation-study-assay” framework (21), provided further input to organize the data quality descriptors into 2 domains: study design and measurements (Figure 1). Such modular structure enables combination of descriptors from the 2 domains. Following recommendations for the reporting of observational studies in epidemiology (20) and nutritional epidemiology (22), we focused on the main study designs for observational studies: cross-sectional, case-control, and cohort studies. In this first instance, the measurements domain was limited to dietary assessment and anthropometric status.

The scoping review led to the development of a search syntax (Supplemental Table 1) to review available literature systematically. Because nutritional epidemiology uses general epidemiologic methods (23), we searched and reviewed all tools for epidemiologic studies. The consortium discussed the procedures for the data extraction and data extraction templates were before the search and are available on request.

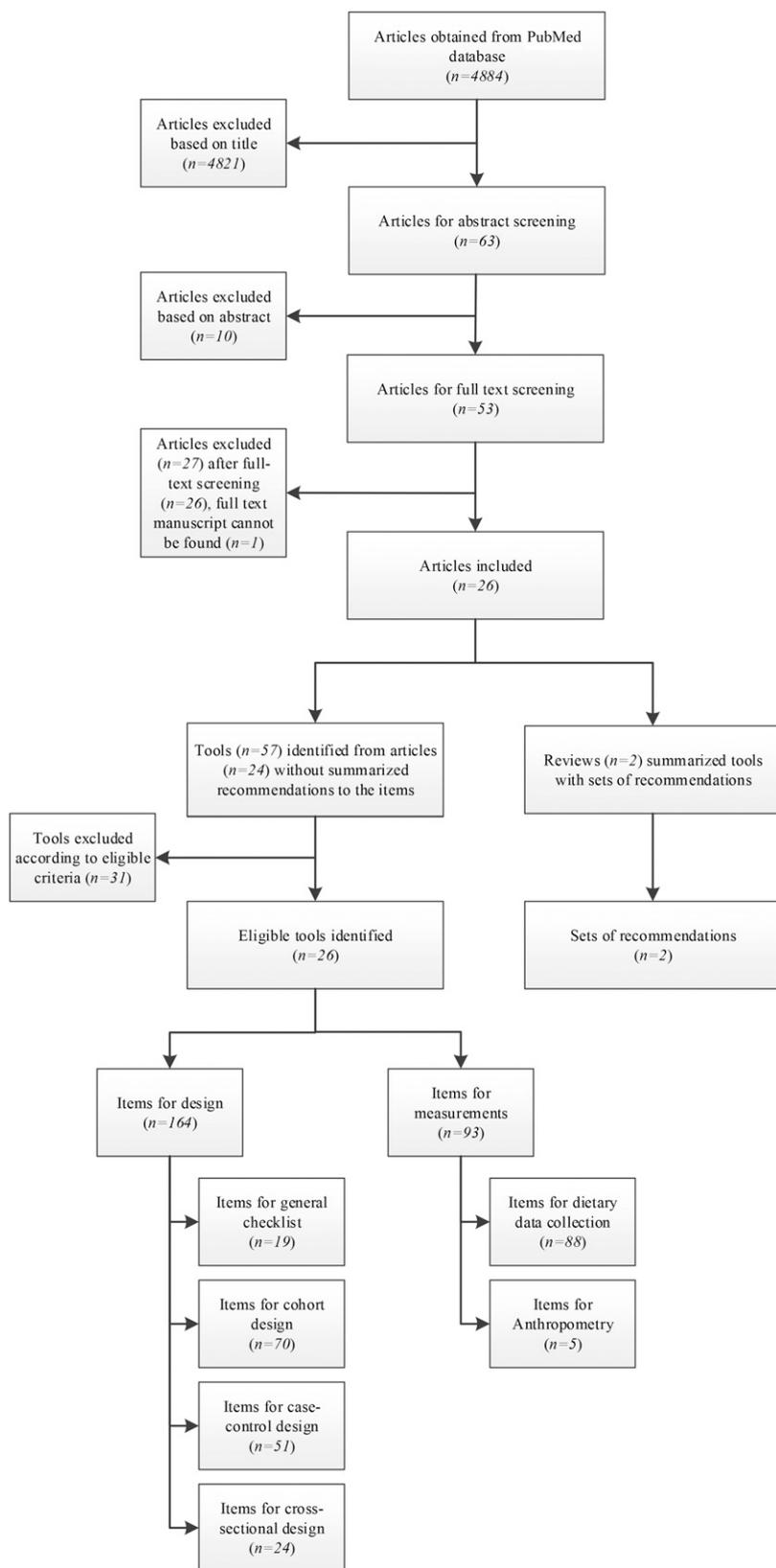


FIGURE 2 Flowchart of study screening and extraction of items for essential study quality characteristics.

MEDLINE (entry: PubMed) was searched twice by MP to retrieve relevant tools. A first search was performed on 1 July 2015, with the limit for publication dates set between 1 January 2000 and 31 December 2015. Because the search syntax did not retrieve some essential tools, a second search was performed on 8 July 2015 using broader search syntax (Supplemental

Table 1) with higher sensitivity and extended publication dates from 1 January 1990 to 31 December 2015.

Studies were included if they met the following criteria: studies that developed instruments with items assessing 1) the methodological quality of ≥ 1 of the following study designs: cohort and panel studies, case-control

TABLE 1 Eligible study quality appraisal tools identified from the literature review¹

Tool name (ref)	Study design			Measurement	
	Case-control	Cross-sectional	Cohort	Diet	Anthropometry
1 Newcastle-Ottawa Scale (31)	x	—	x	—	—
2 SIGN (15)	x	—	x	—	—
3 Friedenreich et al. (32)	x	—	—	x	—
4 Margetts et al. (33)	x	—	x	x	—
5 Yang et al. (34)	x	x	x	x	—
6 NNR5 working group (35)	—	x	x	x	x
7 Hoy et al. (36)	—	x	—	—	—
8 Al-Jader et al. (37)	—	—	—	x	—
9 EPHPP (38)	—	—	—	x	—
10 SAQOR (39)	—	—	—	x	—
11 Giannakopoulos et al. (40)	—	—	—	—	x
12 Thompson et al. (41)	—	—	x	x	—
13 Cho and Bero (42)	—	—	—	—	x
14 Carneiro (43)	x	—	—	—	—
15 CASP (44)	x	—	x	—	—
16 NICE (45)	x	—	x	—	—
17 AHRQ (46)	—	x	—	x	—
18 Crombie's items (47)	x	x	x	x	—
19 NCCEH (48)	—	x	—	x	x
20 CEBMa (49)	x	—	x	x	—
21 EAI (50)	x	x	x	x	x
22 NHMRC (51)	x	—	x	—	—
23 Greenhalgh (52)	x	x	x	—	—
24 Greenhalgh and Taylor (53)	—	—	—	x	—
25 Heller et al. (54)	x	—	—	—	—
26 QATSDD (55)	—	—	—	x	—
27 Sanderson et al. (13) (recommendations)	x	x	x	—	—
28 Deeks et al. (18) (recommendations)	x	x	x	—	—
Total	16	10	15	15	5

¹ The "x" means the tool includes quality appraisal item(s) for that design. AHRQ, Agency for Healthcare Research and Quality; CASP, Critical Appraisal Skills Programme; CEBMa, Center for Evidence-Based Management; EAI, epidemiological appraisal instrument; EPHPP, Effective Public Health Practice Project; NCCEH, National Collaborating Centre for Environmental Health; NHMRC, National Health and Medical Research Council; NICE, National Institute for Health and Care Excellence; NNR, Nordic Nutrition Recommendations; QATSDD, Quality Assessment Tool for Studies with Diverse Designs; ref, reference; SAQOR, Systematic Assessment of Quality in Observational Research; SIGN, Scottish Intercollegiate Guidelines Network.

studies, and cross-sectional studies and analyses, transversal studies, and prevalence studies, and 2) the methodological quality of ≥ 1 of the measurements done in nutritional epidemiology: diet, food intake or anthropometry. Items were excluded if they assessed 1) statistical analysis or assessment of study results and 2) the reporting quality of studies.

Two reviewers screened titles (CL and MP) and abstracts (CY and MP) independently. Before data extraction, the independent reviewers (CL and MP) screened the full text of the selected studies. Reference lists from the included studies were manually searched to identify additional eligible studies. Disagreements were resolved by discussion until consensus was achieved. In case of doubt, we used a conservative approach and included the studies.

A pre-established data extraction form was used to summarize relevant studies, instruments, and quality appraisal items of the included studies.

Step 2: selection and modification of items

On 18 March 2016, a face-to-face meeting with ENPADASI researchers involved in the development of standards and identification of data sets for joint data analysis was organized in Brussels to define essential descriptors. At the inception of the meeting, the guiding principles for item selection and modification were determined. The principles used were 1) independent nature of the descriptors (i.e., every descriptor must capture a distinct data quality parameter), 2) conciseness (i.e., the number of descriptors of the tool should be as concise as possible), 3) objectiveness (i.e., those specifying the data characteristics should be able to provide an objective assessment of how the study was done without value judgment), and 4) generalizability (i.e., the descriptors can be applied to other nutrition study data systems).

Because the discussions were based on existing items from the literature study, the tool made use of existing knowledge as much as possible. The selection and modification of specific descriptors was conducted in small working groups of 3–5 people that were moderated by the lead researchers

of this report (CY, MP, and CL). After the face-to-face meeting, the working groups finalized a draft of the study descriptors through conference calls and e-mail communications.

Step 3: consensus building

A conference call was organized on 10 May 2016 to reach consensus within the working group that participated in the face-to-face meeting on the short-listed descriptors and labels. Absent researchers were informed about the tool and were encouraged to provide comments electronically.

Final consensus in the ENPADASI consortium was obtained during the annual meeting held on 5 September 2016 in Copenhagen, Denmark. During the first week of August, all attendees received the relevant material for the discussion, which included the draft proposed by the working group with a short description of the objective of the study descriptors. Then, standardized definitions of identified terms in quality descriptors were retrieved from the Medical Subject Headings database of US National Library of Medicine (24) and *A Dictionary of Epidemiology* (Sixth Edition) (25). In case terms were not found, manuscripts were used to describe the terms (26–30).

We achieved consensus on the structure, the scope, and description of the included descriptors and how they should be implemented in the DASH-IN database. Unresolved disagreements were further discussed thereafter through electronic communications or conference calls, or both, until final consensus was reached.

Results

Step 1: literature review

We identified 4884 citations after removal of duplicates from the 2 literature searches, of which 24 studies (containing 26

TABLE 2 Items for quality assessment of study design¹

No.	Case-control	Cross-sectional	Cohort	Descriptors	Label	Referred definition
1	x	x	x	Response rate	<ul style="list-style-type: none"> • Response rate: _____ • Cooperation rate: _____ 	<p>Response rate (25): The number of completed or returned survey instruments (questionnaires, interviews, etc.) divided by the total number of persons who would have been surveyed if all had participated. Usually expressed as a percentage. Nonresponse can have several causes (e.g., death, removal from the survey community, and refusal).</p> <p>Cooperation rate (27): The number of participants divided by the number eligible that were ever contacted.</p>
2	x	x	x	Covariates and confounding factors	<ul style="list-style-type: none"> • Both are unknown • Yes, all identified covariates and confounding factors are assessed • Yes, some of the identified covariates and confounding factors are assessed • No, they are not assessed 	<p>Confounding (25): Loosely, the distortion of a measure of the effect of an exposure on an outcome due to the association of the exposure with other factors that influence the occurrence of the outcome. Confounding occurs when all or part of the apparent association between the exposure and outcome is in fact accounted for by other variables that affect the outcome and are not themselves affected by exposure.</p>
3	x	x	x	Confirmed diagnosis ²	<ul style="list-style-type: none"> • Yes, method used for confirming diagnosis: _____ • No, a non-validated self-report diagnosis was used 	<p>Diagnosis (25): The process of determining the health status and the factors responsible for it; may be applied to an individual, family, group, or society. The term is applied both to the process of determination and to its findings.</p>
4	x	x	x	Percentage of missing data for the main exposure(s)/ outcome	<ul style="list-style-type: none"> • Exact percentage (exposure): _____ • Exact percentage (outcome): _____ 	<p>Missing data (25): Lack of some information or incomplete information for some study participants. Usually (but not always) the term refers to data missing in ways deviating from the study design.</p>
5	x	x	x	Pattern of missing data	<ul style="list-style-type: none"> • Missing (completely) at random 	<p>Missing completely at random (25): There are no systematic differences between the missing values and the observed values.</p>

(Continued)

TABLE 2 (Continued)

No.	Case-control	Cross-sectional	Cohort	Descriptors	Label	Referred definition
						Missing at random (25): Any systematic difference between the missing values and the observed values can be explained by differences in observed data.
					• Missing, not at random	Missing, not at random (25): Even after the observed data are taken into account, systematic differences remain between the missing values and the observed values.
6	—	x	x	Random selection	• Unknown • Yes • No	Selection bias (25): Bias in the estimated association or effect of an exposure on an outcome that arises from the procedures used to select individuals into the study or the analysis. When the selection involves conditioning on a factor that is affected by the exposure or a cause of the exposure, and also affected by the outcome or a cause of the outcome, selection bias can arise even in the absence of a causal effect of exposure on outcome.
7	x (if applicable)	x	x (if applicable)	Representative sample	• Yes: representative sample for the study population • No, a nonrepresentative sample was taken	Representative sample (25): A sample that to a large extent resembles a population of interest.
8	x	—	x	Incidence	• Yes, cases reported as incident cases • No, cases not reported as incident cases	Incidence (25): The number of instances of illness commencing, or of persons falling ill, during a given period in a specified population. More generally, the number of new health-related events in a defined population within a specified period of time. It may be measured as a frequency count, a rate, or a proportion.
9	x	—	—	Controls	• Controls are from the same population as cases • Controls are from similar population as cases • Controls are from another population or national controls	Controls (25): Subjects with whom a comparison is made. In a case-control study, controls are often defined as noncases or by other postexposure events, making them especially susceptible to selection bias. Selection of appropriate controls is crucial to the validity of epidemiologic and clinical studies.

(Continued)

TABLE 2 (Continued)

No.	Case-control	Cross-sectional	Cohort	Descriptors	Label	Referred definition
10	—	—	x	Lost to follow-up	<ul style="list-style-type: none"> • <5% • 5–20% • >20% • Unknown 	Lost to follow-up (24, 25): Study subjects in cohort studies whose outcomes are unknown (e.g., because they could not or did not wish to attend follow-up visits).

¹ The “x” means the tool includes quality appraisal item(s) for that design.

² For a data set with >1 outcome, it is better to provide an answer for each of the outcomes.

tools) were finally selected for inclusion and data extraction (Figure 2). Recommendations from 2 relevant systematic reviews were also considered (13, 18). Although both systematic reviews have much broader scopes compared with the present study, their recommendations were considered key to guide the selection of descriptors.

From the 26 selected tools and 2 sets of recommendations, 16, 10, and 15 contained relevant items for design of case-control, cross-sectional, and cohort studies, respectively, and 15 and 5 tools contained items to assess quality of measuring food intake and anthropometry, respectively (Table 1).

Step 2: selection and modification of descriptors

All of the 18 invited ENPADASI partners participated in the face-to-face meeting. During the workshop, 164 items derived from the 26 eligible tools were considered for assessment of the study design and 93 items for measurement assessment. After discussion, the working groups proposed a draft tool with 10 quality descriptors for study design and 22 quality descriptors for nutritional measurements (16 for dietary intake and 6 for anthropometry).

Step 3: consensus building

There were 35 attendees at the ENPADASI consortium meeting. The meeting participants agreed to organize the descriptors as an ordinal scale without an overall score. Meanwhile, controlled vocabularies were added to most of the descriptors in Tables 2–4 to ensure a common understanding and correct interpretation for each of them.

Table 2 contains the 10 descriptors related to study design. Among the 10 descriptors, 6 descriptors are applicable for all the 3 included study designs. For the remainder, the descriptor “random selection” applies to cohort and cross-sectional study designs. The descriptor for “incidence” applies to case-control and cohort study designs. The descriptors for “controls” and “loss to follow-up” were identified for case-control and cohort study designs, respectively. Among the 6 general descriptors, descriptor “representative sample” might not be applicable for case-control studies or cohort studies in some cases. Three types of information should be provided: 1) exact response and cooperation rate, 2) diagnosis method, and 3) missing data rate.

Table 3 summarizes the 16 quality descriptors for dietary assessment by the most popular data collection instruments (i.e., dietary record, 24-h recall, FFQ and screener, and dietary history). These descriptors include 2 items for recall method (descriptor “type of administration” and “the time

of diet records”), 5 for data collection instruments (descriptor “origin of the questionnaire,” “content validity of questionnaire assessed,” “reference of the validation,” “validated elements” and “type of validation”), 4 for representativeness of days (descriptor “representativeness of seasons,” “representativeness of the week/weekend days,” “number of days of the recall/measurement per individual,” and “selection of recall/measurement days selected”), and 5 for the food quantification method (descriptor “quantification of portion sizes,” “description of food intake data,” “geographically specific food composition data,” “matching consumed food to referred food composition data.” and “customized food quantification method based on characters of population groups”). To date, traditional methods are combined with digital technologies, such as 1) dietary assessment through personal digital assistant technologies, mobile phone-based technologies, camera and tape recorder-based technologies developed from dietary record, 2) interactive computer-based technologies, web-based developed from 24-h dietary recall, and 3) interactive computer- and web-based technologies developed from the FFQ (56). The data quality descriptors can be equally used for these combined methods.

Table 4 summarizes 6 descriptors for anthropometry measurement, which focused on training of assessors, weight, height, waist circumference, BMI status (categories), and whole-body adiposity.

Discussion

Here, we propose essential quality descriptors for study data from nutritional epidemiology. Unlike existing quality assessment tools for studies, the present set of quality descriptors provides essential items to be added as metadata of nutrition research data. Apart from having a different scope, the present set of descriptors has several differences compared with existing tools.

First, existing quality appraisal tools assign quality scores to studies. Unlike these tools, the present set of descriptors describes essential quality aspects of the study without ranking or scoring studies and their data. Because data quality requirements depend on the purpose of the research, an absolute assessment of study quality was considered unrealistic. As such, data quality might be judged acceptable for one specific purpose but not for another. Instead of assessing absolute quality, the present tool ensures that studies are adequately characterized with descriptors relevant for assessing

TABLE 3 Items for measurement of diet and food intake¹

No.	Dietary record	24-h recall	FFQ and screener	Dietary history	Descriptors	Label	Referred definition
1	x	x	x	x	Type of administration	<ul style="list-style-type: none"> • Proxy administered • Self-administered and not verified by interviewer • Self-administered and checked by interviewer • Interview administered • Interview administered using automated multiple-pass method 	Automated multiple-pass method (26); Computerized method for collecting interviewer-administered 24-h dietary recalls either in person or by telephone.
2	x	x	x	x	Origin of the questionnaire	<ul style="list-style-type: none"> • Self-developed questionnaires • Use of standardized questionnaire • Adopted other questionnaires 	Questionnaires (25): A predetermined set of questions used to collect data—clinical data, social status, occupational group, etc. This term is often applied to a self-completed survey instrument, as contrasted with an interview schedule.
3 (if 2 = self-developed questionnaires)	x	x	x	x	Content validity of questionnaire assessed	<ul style="list-style-type: none"> • No • Yes, in another population • Yes, in a comparable population in terms of both age and dietary habits 	Content validity (25): The extent to which the measurement incorporates the domain of the phenomenon under study. For example, a measurement of functional health status should embrace activities of daily living (occupational, family, and social functioning, etc.).
4 (if 3 = yes)	x	x	x	x	Reference of the validation ²	<ul style="list-style-type: none"> • No validation was conducted • Comparison with subjective dietary assessment methods (e.g., FFQ, 24-h recall, or short term dietary record) • Comparison with long-term weighted dietary record (>7 d) • Comparison with objective methods (e.g., biomarker of dietary intake) 	Biomarker (25): A substance, structure, or process that can be measured in biological specimens or media and may be associated with health outcomes or biological effects. A cellular, biochemical, or molecular indicator of exposure; of biological, subclinical, or clinical effects; or of possible susceptibility. A biological indicator of internal dose, biologically effective dose, early biological response, altered structure, or altered function.
5 (if 3 = yes)	x	x	x	x	Validated element(s)	<ul style="list-style-type: none"> • Properties of the whole questionnaire (e.g., interrater reliability, etc.) • Frequency options appropriate to identify between-person variations • Food items lead to underestimated target nutrients intake (for FFQ only) • Others 	—

(Continued)

TABLE 3 (Continued)

No.	Dietary record	24-h recall	FFQ and screener	Dietary history	Descriptors	Label	Referred definition
6 (if 3 = yes)	x	x	x	x	Type of validation	<ul style="list-style-type: none"> • Concurrent validity or precision only • Concurrent validity and precision 	—
7	x	x	x	x	Representativeness of seasons	<ul style="list-style-type: none"> • All seasons • Not all seasons 	Seasons (24): Divisions of the year according to some regularly recurrent phenomena usually astronomical or climatic.
8	x	x	x	x	Quantification of portion sizes	<ul style="list-style-type: none"> • Not quantified • Standard portion sizes without aids • Standard portion sizes with aids such as pictures, models, standard household measure, utensils, etc. • Portion sizes are assessed digitally but not verified by trained staff • Portion sizes are assessed digitally and verified by trained staff (or packaging) 	Portion size (24): The amount of a particular food one chooses to eat at a single meal.
9 (if 8 ≠ not quantified)	x	x	x	x	Description of food intake data	<ul style="list-style-type: none"> • Food intake is directly expressed into units of weights or volume (for weighed food record) • Food intake is converted from estimated portion sizes into units of weights or volume • Portion sizes are not converted 	Portion size (24): The amount of a particular food one chooses to eat at a single meal.
10 (if 8 ≠ not quantified)	x	x	x	x	Geographically specific food composition data	<ul style="list-style-type: none"> • Yes • No 	Geographically specific food composition data (28): In a single country there may be a wide diversity of soil and climatic conditions, resulting in significant variance in food composition. Variations in food marketing and food preparation within different parts of a country—or between countries in the case of a multicountry database—may also produce notable variance. For these reasons, geographically specific data may be presented in the database as a supplement to nationwide and/or region-wide averages.
11 (if 8 ≠ not quantified)	x	x	x	x	Matching consumed food to referred food composition data	<ul style="list-style-type: none"> • ___% food items with exact matching • ___% food items matched to means of ≥ 3 food items in the table 	Food matching links food consumption data with food composition data and affects the quality of the dietary assessment

(Continued)

TABLE 3 (Continued)

No.	Dietary record	24-h recall	FFQ and screener	Dietary history	Descriptors	Label	Referred definition
						<ul style="list-style-type: none"> • ___% food items matched to same food items in the table with similar moisture content • ___% matched to a different food 	and accuracy of findings. High-quality matching is desirable but is often not achievable due to lack of food composition data or information on food consumed. Exact match (29): If food description reported in 24-h recall matched exactly with the description in food consumption data.
12	x	x	—	x	Representativeness of the week/weekend days	<ul style="list-style-type: none"> • Only weekend days • Only weekdays • Both • n/a 	—
13	x	x	—	x	Number of days of the recall/ measurement per individual	<ul style="list-style-type: none"> • 1 d • 2–7 d • >7 d 	—
14	x	x	—	x	Selection of recall/ measurement days selected	<ul style="list-style-type: none"> • Convenience selection • Consecutive days • Nonconsecutive, nonrandom days • Randomly over the week 	—
15	x	—	x	x	The time of diet records	<ul style="list-style-type: none"> • Not during eating occasions or immediately after • Immediately after eating occasion • During eating occasion 	Diet records (24): Records of nutrient intake over a specific period of time, usually kept by the patient.
16	—	—	x	x	Customized food quantification method based on characters of population groups	<ul style="list-style-type: none"> • The method was tailored to the characteristics of the population assessed • The method was not specifically tailored to the characteristics of the population assessed • Unknown 	Population groups (24): Individuals classified according to their sex, racial origin, religion, common place of living, financial or social status, or some other cultural or behavioral attribute.

¹ The “x” means the item is applicable for that design. n/a, not available.

² If applicable, tick multiple options to describe the combination of methods.

data quality by the user of the data. In doing so, researchers extracting data from nutrition data research infrastructure can determine quality parameters and boundaries relative to their specific research interest. By requesting data providers to describe data quality, we avoid quality assessment from external assessors. No predefined quality scores are provided because this could trigger data providers to indicate a better quality of their data with respect to the “most important” quality measures.

Second, because the tool describes methodological aspects of nutritional epidemiologic data, descriptors for data analysis and data interpretation were not considered. Such items are typically included in tools that appraise study quality based on information reported in manuscripts (13).

Third, throughout the discussion, we decided to allocate several items under minimal study data requirements. These minimal study data requirements are mandatory and ensure

basic information is added to describe uploaded data for interpretation and use. For instance, previous studies indicate that the source of funding could bias study findings (57). This information was considered different from the methodological aspects and rather part of minimal study data requirements. Unlike the minimal study data requirements, descriptors related to study quality are presented as an optional set of questions for those uploading data to databases. The number of answered descriptors, however, can also be used as a quality parameter to indicate how well uploaded data are described.

To minimize the burden to the data providers, only descriptors related to methodological issues of data collection were considered. We acknowledge that the methodological considerations of studies here are only one aspect to describe data quality (58). Equally relevant to data quality are data entry accuracy and data completeness. This information,

TABLE 4 Descriptors for measurement of anthropometry

No.	Descriptors	Options	Referred definitions
1	Training of assessors	<ul style="list-style-type: none"> • Self-reported, without assessors or with assessors not trained using standard operating procedures • Trained, not using standard operating procedures • Trained and using predefined standard operating procedures 	Standard operating procedures (30): detailed, written instructions to achieve uniformity of the performance of a specific function.
2	Weight	<ul style="list-style-type: none"> • Self-measured, self-reported or proxy reported • Measured with no clothing instructions by an assessor 	<p>Proxy (24): A person authorized to decide or act for another person, for example, a person having durable power of attorney.</p> <p>Body weight (24): The mass or quantity of heaviness of an individual. It is expressed by units of pounds or kilograms.</p>
3	Height	<ul style="list-style-type: none"> • Measured naked or with only light clothing by an assessor • Self-measured, self-reported, or proxy reported • Measured with shoes 	<p>Proxy (24): A person authorized to decide or act for another person, for example, a person having durable power of attorney.</p> <p>Body height (24): The distance from the sole to the crown of the head with body standing on a flat surface and fully extended.</p>
4	Waist circumference	<ul style="list-style-type: none"> • Measured barefoot • Self-measured, self-reported, or proxy reported • Measured with no clothing instructions 	<p>Proxy (24): A person authorized to decide or act for another person, for example, a person having durable power of attorney.</p> <p>Waist circumference (24): The measurement around the body at the level of the abdomen and just above the hip bone. The measurement is usually taken immediately after exhalation.</p>
5	BMI status (categories)	<ul style="list-style-type: none"> • Measured naked or with only light clothing • Self-reported using no aids • Assessed using pictograms or silhouettes • Measured using objective measures (weight and height, body scanner...) 	BMI (25): BMI, anthropometric measure, defined as kg/m^2 .
6	Whole-body adiposity	<ul style="list-style-type: none"> • Using bioelectrical impedance analysis • Using DXA • Waist-to-hip ratio • Skin fold 	Adiposity (24): The amount of fat or lipid deposit at a site or an organ in the body, an indicator of body fat status.

however, can be assessed objectively from the data and does not require additional information provided by data providers (30). A combination of methodological and statistical aspects (e.g., data entry accuracy, data completeness, data cleaning approaches, etc.) of data is needed to fully describe data quality. Further efforts will be devoted to developing data quality descriptors based on statistical aspects of data in the next years.

Information collected through the data descriptors will be made available to those interacting with the DASH-IN (14) system as options during the construction of data queries. When users extract data from the system, study descriptors will be available that allow users to 1) construct queries by choosing appropriate study quality descriptors and minimal study data requirements and 2) check the quality characteristics of data retrieved by a query. To guide users toward the best data source, a summary statistic will be provided to indicate the relative share of its descriptors filled. Querying of the data system using the descriptors will hence enable exploratory and associational analysis and predictive modeling.

Together with minimal study data requirements, we integrated the set of essential quality descriptors in Mica (59), an open-access infrastructure to describe and share epidemiologic data. The JavaScript Object Notation script to define

the descriptors in Mica is available publicly to encourage use and further development (<https://github.com/enpadasi/enpadasi-mica-forms>).

As a generic tool for observational data in nutrition, this tool can be applied to nutrition data systems other than DASH-IN and is a relevant contribution to initiatives such as the Global Dietary Database (7), which collects pooled food intake data worldwide. Similarly, the FAO/WHO Global Individual Food Consumption Data Tool aims to make food intake data available for reuse and analysis (60). Adding the tool to the templates and study data descriptors will enable the careful consideration of the quality of data considered and sensitivity of the pooled analysis.

The present report describes a controlled vocabulary of study descriptors by an interdisciplinary group of domain experts. Additional efforts are needed to integrate them in the nutrition research data infrastructure, including DASH-IN, among others. Machine-operable terms and their relations, attributes, and values are required to enable the interoperability of data (61, 62). To ensure interoperability of nutrition data systems, ENPADASI is developing an Ontology for Nutritional Studies (ONS) (26, 63). All descriptors of these study data characteristics will be made part of ONS and implemented

as such in the research infrastructure. The descriptors for data quality will be mapped to existing or newly developed ontology terms. Integration of study quality characteristics with the ONS will enable the consideration of study quality during the querying of the nutrition research infrastructure and interoperability with other data systems.

The present set of descriptors was informed by existing tools and guidance on study quality appraisal. Our search, however, was limited to MEDLINE, and although it is considered as the most comprehensive database for medical literature to date, we are conscious that we may have missed some quality appraisal tools. The aim of the literature search, however, was to derive a set of quality descriptors that could be discussed and complemented by consortium participants in a consecutive consultation.

Although validity and reliability assessment of a tool are essential, these properties have only been assessed for a few quality appraisal instruments until now (64). During the following years, the set of descriptors will be evaluated and extra modules will be added. The modular structure of the tool enables easy integration of descriptors related to other study designs (e.g., intervention study, etc.) or measurements (e.g., physical activity, smoking, etc.). In addition, data descriptors of both observational and intervention studies will be linked in DASH-IN to enable the description and extraction of data from hybrid collection events (e.g., observational analyses from clinical trials, etc.). Care will be taken not to inflate the number of descriptors to go beyond what is practically acceptable by data providers. An online survey for both those uploading and extracting data will be organized to determine the acceptable number of descriptors in the tool.

The descriptors of quality characteristics proposed in the present report will contribute to an adequate description of nutritional and dietary intake data as a determinant of disease and can facilitate the re-use and uncertainty analysis of risk factors for diseases in this regard.

Acknowledgments

The authors' responsibilities were as follows—CL and CY: conceived and designed the research; CL, CY, and MP: conducted the research; CY, MP, PK, JVC, NDC, KN, TP, EL, GP, RC, AH, MS-M, LOD, SMP, ID, JB, PC, FM, MDA, MG, JT, OC, DC, HDR, JW, LK, CM, BDB, GDT, AB, AR, RG, RL, SDC, and CL: drafted the list of descriptors and wrote the first draft of the manuscript; and all authors: revised the manuscript and read and approved the final version of the manuscript.

References

- Lim SS, Vos T, Flaxman AD, Danaei G, Shibuya K, Adair-Rohani H, Amann M, Anderson HR, Andrews KG, Aryee M, et al. A comparative risk assessment of burden of disease and injury attributable to 67 risk factors and risk factor clusters in 21 regions, 1990–2010: a systematic analysis for the Global Burden of Disease Study 2010. *Lancet* 2012;380:2224–60.
- Ligthelm RJ, Borzi V, Gumprecht J, Kawamori R, Yang WY, Valensi P. Importance of observational studies in clinical practice. *Clin Ther* 2007;29:1284–92.
- Carlson MD, Morrison RS. Study design, precision, and validity in observational studies. *J Palliat Med* 2009;12:77–82.
- Byers T. The role of epidemiology in developing nutritional recommendations: past, present, and future. *Am J Clin Nutr* 1999;69:1304S–8S.
- van Ommen B, Bouwman J, Dragsted LO, Drevon CA, Elliott R, de Groot P, Kaput J, Mathers JC, Muller M, Pepping F, et al. Challenges of molecular nutrition research 6: the nutritional phenotype database to store, share and evaluate nutritional systems biology studies. *Genes Nutr* 2010;5:189–203.
- NCD Risk Factor Collaboration (NCD-RisC). Trends in adult body-mass index in 200 countries from 1975 to 2014: a pooled analysis of 1698 population-based measurement studies with 19.2 million participants. *Lancet* 2016;387:1377–96.
- Del Gobbo LC, Khatibzadeh S, Imamura F, Micha R, Shi P, Smith M, Myers SS, Mozaffarian D. Assessing global dietary habits: a comparison of national estimates from the FAO and the Global Dietary Database. *Am J Clin Nutr* 2015;101:1038–46.
- Sorensen HT, Sabroe S, Olsen J. A framework for evaluation of secondary data sources for epidemiological research. *Int J Epidemiol* 1996;25:435–42.
- Wilkinson MD, Dumontier M, Aalbersberg IJ, Appleton G, Axton M, Baak A, Blomberg N, Boiten JW, da Silva Santos LB, Bourne PE, et al. The FAIR guiding principles for scientific data management and stewardship. *Sci Data* 2016;3:160018.
- Mathers CD. Uncertainty and data availability for the global burden of disease estimates 2000–2002. Geneva (Switzerland): WHO; 2005.
- Stroup DF, Berlin JA, Morton SC, Olkin I, Williamson GD, Rennie D, Moher D, Becker BJ, Sipe TA, Thacker SB. Meta-analysis of observational studies in epidemiology: a proposal for reporting. Meta-analysis Of Observational Studies in Epidemiology (MOOSE) group. *JAMA* 2000;283:2008–12.
- Colditz GA, Burdick E, Mosteller F. Heterogeneity in meta-analysis of data from epidemiologic studies: a commentary. *Am J Epidemiol* 1995;142:371–82.
- Sanderson S, Tatt ID, Higgins JP. Tools for assessing quality and susceptibility to bias in observational studies in epidemiology: a systematic review and annotated bibliography. *Int J Epidemiol* 2007;36:666–76.
- ENPADASI. Phenotype database (DASH-IN) [Internet]. [cited 2017 May 17]. Available from: <https://dashin.eu/interventionstudies/>.
- Scottish Intercollegiate Guidelines Network (SIGN). Methodology checklist 3 & 4 for cohort and case-control studies. 7th September [Internet]. [cited 2016 Jan 20]. Available from: <http://www.sign.ac.uk/checklists-and-notes.html>.
- Higgins J, Green S. *Cochrane handbook for systematic reviews of interventions* version 5.1.0. Oxford (United Kingdom): The Cochrane Collaboration; 2011.
- Katruk P, Bialocerkowski AE, Massy-Westropp N, Kumar S, Grimmer KA. A systematic review of the content of critical appraisal tools. *BMC Med Res Methodol* 2004;4:22.
- Deeks JJ, Dinnes J, D'Amico R, Sowden AJ, Sakarovich C, Song F, Petticrew M, Altman DG; International Stroke Trial Collaborative Group, European Carotid Surgery Trial Collaborative Group. Evaluating non-randomised intervention studies. *Health Technol Assess* 2003;7:iii–x, 1–173.
- Crowe M, Sheppard L. A general critical appraisal tool: an evaluation of construct validity. *Int J Nurs Stud* 2011;48:1505–16.
- von Elm E, Altman DG, Egger M, Pocock SJ, Gøtzsche PC, Vandenbroucke JP; STROBE-Initiative. The Strengthening the Reporting of Observational Studies in Epidemiology (STROBE) statement: guidelines for reporting observational studies. *PLoS Med* 2007;4:e296.
- Sansone SA, Rocca-Serra P, Field D, Maguire E, Taylor C, Hofmann O, Fang H, Neumann S, Tong W, Amaral-Zettler L, et al. Toward interoperable bioscience data. *Nat Genet* 2012;44:121–6.
- Lachat C, Hawwash D, Ocke MC, Berg C, Forsum E, Hornell A, Larsson C, Sonestedt E, Wirfalt E, Akesson A, et al. Strengthening the Reporting of Observational Studies in Epidemiology-Nutritional Epidemiology (STROBE-nut): an extension of the STROBE Statement. *PLoS Med* 2016;13:e1002036.
- Willett W. *Nutritional epidemiology*. New York: Oxford University Press; 1998.

24. National Library of Medicine. Medical subject headings [Internet]. 2017. [cited 2016 Nov 25]. Available from: <https://www.nlm.nih.gov/mesh/meshhome.html>.
25. Porta M. A dictionary of epidemiology. 6th ed. [Internet]. [cited 2017 Apr 26]. Available from: <http://www.oxfordreference.com/view/10.1093/acref/9780199976720.001.0001/acref-9780199976720>.
26. Raper N, Perloff B, Ingwersen L, Steinfeldt L, Anand J. An overview of USDA's dietary intake data system. *J Food Compos Anal* 2004;17:545–55.
27. The American Association for Public Opinion Research. Standard definitions: final dispositions of case codes and outcome rates for surveys. 9th ed. Oakbrook Terrace (IL): AAPOR; 2016.
28. Greenfield H, Southgate DA. Food composition data: production, management and use. 2nd ed. Rome (Italy): FAO UN; 2003.
29. FAO/INFOODS. FAO/INFOODS Guidelines for food matching. Version 1.2. Rome (Italy): FAO; 2012.
30. Bergdahl M, Ehling M, Elvers E, Földesi E, Körner T, Kron A, Lohaus P, Mag K, Morais V, Nimmergut A, et al.. Handbook on data quality assessment methods and tools. Wiesbaden (Germany): European Commission Eurostat; 2007.
31. Wells GA, Shea B, O'Connell D, Peterson J, Welch V, Losos M, Tugwell P. The Newcastle-Ottawa Scale (NOS) for assessing the quality of nonrandomised studies in meta-analyses. [Internet]. [cited 2015 Mar 17]. Available from: http://www.ohri.ca/programs/clinical_epidemiology/oxford.htm.
32. Friedenreich CM, Brant RF, Riboli E. Influence of methodologic factors in a pooled analysis of 13 case-control studies of colorectal cancer and dietary fiber. *Epidemiology* 1994;5:66–79.
33. Margetts BM, Thompson RL, Key T, Duffy S, Nelson M, Bingham S, Wiseman M. Development of a scoring system to judge the scientific quality of information from case-control and cohort studies of nutrition and disease. *Nutr Cancer* 1995;24:231–9.
34. Yang WY, Burrows T, MacDonald-Wicks L, Williams LT, Collins C, Chee WS. Quality of dietary assessment methodology and reporting in epidemiology studies examining relationship between dietary outcome and childhood obesity in developing Asian countries: a systematic review. *Nutr Diet* 2014;71:201–9.
35. NNR5 Working Group. A guide for conducting systematic literature reviews for the 5th edition of the Nordic Nutrition Recommendations. Revised ed. Copenhagen (Denmark): Nordic Council of Ministers; 2011.
36. Hoy D, Brooks P, Woolf A, Blyth F, March L, Bain C, Baker P, Smith E, Buchbinder R. Assessing risk of bias in prevalence studies: modification of an existing tool and evidence of interrater agreement. *J Clin Epidemiol* 2012;65:934–9.
37. Al-Jader LN, Newcombe RG, Hayes S, Murray A, Layzell J, Harper PS. Developing a quality scoring system for epidemiological surveys of genetic disorders. *Clin Genet* 2002;62:230–4.
38. Jackson N, Waters E. Guidelines for Systematic Reviews in Health Promotion and Public Health Taskforce. Criteria for the systematic review of health promotion and public health interventions. *Health Promot Int* 2005;20:367–74.
39. Ross LE, Grigoriadis S, Mamisashvili L, Koren G, Steiner M, Dennis CL, Cheung A, Mousmanis P. Quality assessment of observational studies in psychiatry: an example from perinatal psychiatric research. *Int J Methods Psychiatr Res* 2011;20:224–34.
40. Giannakopoulos NN, Rammelsberg P, Eberhard L, Schmitter M. A new instrument for assessing the quality of studies on prevalence. *Clin Oral Investig* 2012;16:781–8.
41. Thompson S, Ekelund U, Jebb S, Lindroos AK, Mander A, Sharp S, Turner R, Wilks D. A proposed method of bias adjustment for meta-analyses of published observational studies. *Int J Epidemiol* 2011;40:765–77.
42. Cho MK, Bero LA. Instruments for assessing the quality of drug studies published in the medical literature. *JAMA* 1994;272:101–4.
43. Carneiro AV. Critical appraisal of prognostic evidence: practical rules. *Rev Port Cardiol* 2002;21:891–900.
44. Singh J. Critical appraisal skills programme. *J Pharmacol Pharmacother* 2013;4:76.
45. National Institute for Health and Care Excellence. National Institute for Health and Care Excellence (NICE). [Internet]. [cited 2016 Jan 20]. Available from: <https://www.nice.org.uk/process/pmg10/chapter/appendix-e-methodology-checklist-casecontrol-studies>.
46. Rostom A, Dubé C, Cranney A, Saloojee N, Sy R, Garrity C, Sampson M, Zhang L, Yazdi F, Mamaladze V, et al. Celiac disease. Evidence report/technology assessment no. 104. (Prepared by the University of Ottawa evidence-based practice center, under contract No. 290-02-0021). Rockville (MD): Agency for Healthcare Research and Quality; 2004.
47. Zeng X, Zhang Y, Kwong JS, Zhang C, Li S, Sun F, Niu Y, Du L. The methodological quality assessment tools for preclinical and clinical studies, systematic review and meta-analysis, and clinical practice guideline: a systematic review. *J Evid Based Med* 2015;8:2–10.
48. National Collaborating Centre for Environmental Health (NCCEH). A primer for evaluating the quality of studies on environmental health. Critical appraisal of cross-sectional studies [Internet]. [updated 2014 Jun 5; cited 2015 Dec 20]. Available from: http://www.nccch.ca/sites/default/files/Critical_Appraisal_Cross-Sectional_Studies_Aug_2011.pdf.
49. Center for Evidence-Based Management (CEBMA). Critical appraisal of case-control study, cohort/panel study and survey [Internet]. [updated 2014 Jun 5; cited 2016 Jan 20]. Available from: <http://www.cebma.org/wp-content/uploads/Critical-Appraisal-Questions-for-a-Case-Control-Study.pdf>.
50. Genaidy AM, Lemasters GK, Lockey J, Succop P, Deddens J, Sobehi T, Dunning K. An epidemiological appraisal instrument - a tool for evaluation of epidemiological studies. *Ergonomics* 2007;50:920–60.
51. National Health and Medical Research Council (NHMRC). How to use the evidence: assessment and application of scientific evidence. Canberra (Australia): National Health and Medical Research Council; 2000.
52. Greenhalgh T. How to read a paper: assessing the methodological quality of published papers. *BMJ* 1997;315:305–8.
53. Greenhalgh T, Taylor R. How to read a paper: papers that go beyond numbers (qualitative research). *BMJ* 1997;315:740–3.
54. Heller RF, Verma A, Gemmell I, Harrison R, Hart J, Edwards R. Critical appraisal for public health: a new checklist. *Public Health* 2008;122:92–8.
55. Sirriyeh R, Lawton R, Gardner P, Armitage G. Reviewing studies with diverse designs: the development and evaluation of a new tool. *J Eval Clin Pract* 2012;18:746–52.
56. Illner AK, Freisling H, Boeing H, Huybrechts I, Crispim SP, Slimani N. Review and evaluation of innovative technologies for measuring diet in nutritional epidemiology. *Int J Epidemiol* 2012;41:1187–203.
57. Bes-Rastrollo M, Schulze MB, Ruiz-Canela M, Martinez-Gonzalez MA. Financial conflicts of interest and reporting bias regarding the association between sugar-sweetened beverages and weight gain: a systematic review of systematic reviews. *PLOS Med* 2013;10:e1001578.
58. Even A, Shankaranarayan G. Understanding impartial versus utility-driven quality assessment in large datasets. Presented at 12th International Conference on Information Quality; 2007 Nov 9-11, MIT, Cambridge, MA.
59. Maelstrom Research program. Publish with Mica: what is Mica? [Internet]. [cited 2017 June 22]. Available from: <http://www.obiba.org/pages/products/mica/>.
60. Food and Agricultural Organization of the United Nations. Nutrition. FAO/WHO Global Individual Food consumption data Tool (FAO/WHO GIFT) [Internet]. [updated 2016 Mar 22; cited 2016 Aug 19]. Available from: <http://www.fao.org/nutrition/assessment/food-consumption-database/en/>.
61. Preece A, Missier P, Ernbury S, Jin B, Greenwood M. An ontology-based approach to handling information quality in e-science. *Concurr Comp-Pract E* 2008;20:253–64.
62. Min H, Manion FJ, Goralczyk E, Wong YN, Ross E, Beck JR. Integration of prostate cancer clinical data using an ontology. *J Biomed Inform* 2009;42:1035–45.
63. ENPADASI. Ontology-for-nutritional-studies [Internet]. 2016. [cited 2017 Jun 24]. Available from: <https://github.com/enpadasi/Ontology-for-Nutritional-Studies>.
64. Hootman JM, Driban JB, Sitler MR, Harris KP, Cattano NM. Reliability and validity of three quality rating instruments for systematic reviews of observational studies. *Res Synth Methods* 2011;2:110–8.